



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Alleged Nonacceptance of
VA Authorizations by
Community Care Providers

Fayetteville, North Carolina

AUDIT

REPORT # 17-05228-279

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Executive Summary

Why the OIG Did This Audit

In July 2017, the VA Office of Inspector General (OIG) received an allegation that two orthopedic community providers in the Fayetteville, North Carolina, area stopped accepting VA patients because VA and Health Net Federal Services, LLC (Health Net) did not timely pay their medical claims. The OIG conducted this audit to determine whether community care providers associated with the Fayetteville, North Carolina, VA Medical Center (VAMC) stopped accepting Non-VA Care (NVC) and Veterans Choice Program (Choice) authorizations.

VA offers care in the community to help veterans obtain medical appointments for services not provided at their VA facility, appointments not available within 30 days, and where there are more convenient medical care options for veterans living more than 40 miles from their VA facility. VA offers this care primarily through the NVC and Choice Programs, which are separate and have different eligibility criteria and different processes for referrals to providers and payment of claims. VA's Office of Community Care (OCC) staff was responsible for managing NVC medical care, including claims for payments submitted by community providers. VA's third-party administrator was responsible for managing Choice claims submitted by community providers, and under the terms of the Choice contract, it pays claims submitted by the community providers. The Fayetteville VAMC belongs to Veterans Integrated Service Network (VISN) 6, and Health Net is VA's third-party administrator for that VISN.¹ Based on Veterans Health Administration (VHA) data, the Fayetteville VAMC provided care to over 72,500 patients in fiscal year (FY) 2017, of which about 33 percent received care in the community during that time. Conducting an audit of community providers potentially leaving VA's network is important because, if additional providers stop accepting NVC and Choice authorizations, veterans may experience increased wait times and need to travel further distances to obtain their medical care.

What the Audit Found

The OIG substantiated the specific allegation that two orthopedic community providers associated with the Fayetteville VAMC no longer accepted some VA patients, and further determined that additional community providers also stopped accepting VA patients. Specific to the allegation, one orthopedic provider stopped accepting only NVC authorizations, and another orthopedic provider stopped accepting both NVC and Choice authorizations. Based on informal notes maintained by the VAMC schedulers, the OIG determined at least 15 community providers

¹ Patient-Centered Community Care (PC3) is another VA community care program, and is administered by the third-party administrator (Health Net). The OIG did not include PC3 claims in the scope of this audit because VHA data indicated that VA patients obtained care from the community providers discussed in this report almost exclusively by way of NVC and Choice Programs during 2017.

(including the two noted in the allegation) stopped accepting authorizations for VA patients from January 2015 through July 2017. Aside from these notes, the VAMC did not maintain records of which providers stopped accepting VA authorizations. Based on interviews with OCC, the Fayetteville VAMC, and Health Net, the OIG determined these organizations did not effectively monitor community provider participation in the NVC and Choice programs at the local level and could not specifically identify how many community providers stopped accepting, or were accepting, authorizations for Fayetteville VAMC patients.

The OIG contacted the 15 community providers the VAMC believed no longer accepted VA authorizations to verify whether these providers stopped accepting authorizations. Nine community care providers stopped accepting both NVC and Choice authorizations, five continued to accept NVC authorizations but stopped accepting Choice authorizations from Health Net, and one continued to accept Choice authorizations but stopped accepting NVC authorizations from the VAMC. Significantly, the nine providers who stopped accepting both NVC and Choice authorizations offered dermatology (one), neurosurgery (two), orthopedic (two), and urology (four) services to VA patients associated with the Fayetteville VAMC. Prior to severing ties with the VA from January 2015 through July 2017, those providers completed nearly 6,900 patient encounters with about 1,900 VA patients.²

As a result of some providers no longer accepting authorizations, VA and Health Net schedulers encountered challenges in scheduling VA patients for care in the community, which led to increased driving distances to reach NVC or Choice providers and longer wait times. The Fayetteville VAMC Non-VA Care Coordination (NVCC) Chief and the NVCC schedulers stated they had difficulty scheduling VA patients specifically for dermatology, neurosurgery, orthopedic, and urology services in their community. Similarly, Health Net schedulers stated they had a difficult time scheduling veterans' Choice appointments for dermatology, neurology, orthopedic, urology, and pain management services. VAMC and Health Net schedulers stated they conducted internet searches to identify community providers near the veterans' homes when they did not have established local options. However, the VAMC schedulers stated that it was difficult to identify new community providers willing to accept authorizations.

Community care providers cited issues with both VA and Health Net, and stated they stopped accepting NVC and Choice authorizations primarily because VA staff and Health Net did not timely pay their medical claims. Specifically, 11 of the 15 community providers stated they stopped accepting authorizations because they did not receive timely payments; the other four did not provide additional information. VAMC schedulers also stated community providers stopped accepting VA authorizations due to untimely payment. In addition, community care providers noted that VA staff and Health Net did not provide timely assistance responding to

² VHA Directive 1230, *Outpatient Scheduling Processes and Procedures* (July 15, 2016), states, "An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

claim inquiries, which also contributed to the providers' decision to stop accepting NVC and Choice authorizations.

Frustration with VA's Non-VA Care Claims Processing

Ten of the 15 community care providers stopped accepting NVC authorizations from January 2015 through July 2017.³ These 10 providers offered dermatology, neurosurgery, orthopedic, and urology services. The OIG interviewed three of them and learned they did so primarily because VA did not timely process their medical claims, and VISN 6 Claims Adjudication and Reimbursement (CAR) staff did not provide timely assistance responding to their medical claim inquiries. For the 10 community providers who stopped accepting NVC authorizations, CAR approved 2,263 NVC medical claims from January 2015 through July 2017. From January 2017 through July 2017, CAR staff approved 336 medical claims for those community providers in an average of 46 days.⁴ The community care providers the OIG interviewed stated they continued to see VA patients on existing authorizations until patients exhausted their approved number of visits; therefore, these providers may have submitted claims after they decided to stop accepting authorizations.

The CAR NVC Manager stated the VISN 6 CAR office did not meet the demand of incoming NVC claims because they did not use all of their claims examiners exclusively to process NVC claims. Specifically, during FY 2017, CAR staff received, on average, about 90,600 NVC claims per month, and processed, on average, about 85,500 claims per month. As of December 2017, VISN 6 CAR had about 159,000 unprocessed claims, including about 48,600 that were already older than 30 days. Using OCC production goals, the OIG determined that VISN 6 CAR had enough staff to process about 1,100 more claims per month than they received. However, they incurred a backlog of claims because claims examiners also indexed medical records, addressed congressional inquiries, and performed other related work. As a result, CAR staff generally did not process claims within 30 days because they were in a constant state of backlog. VA's payment of medical claims to community providers for NVC claims is governed by the Prompt Payment Act, which requires VA to make payment within 30 days of receipt of the claim.⁵ Accordingly, VA also paid interest for untimely payments. From January 2015 through July 2017, VA paid about \$156,000 in interest for claims associated with the Fayetteville VAMC that CAR did not pay timely.

³ These 10 community care providers include the one that stopped accepting only NVC authorizations, plus the nine providers who stopped accepting both NVC and Choice authorizations.

⁴ Eight of the 10 community providers had claims approved during this specific period; the other two providers did not have claims approved in this time frame.

⁵ While the Choice contract requires that VA pay the third-party administrator within the timeliness standard imposed by the Prompt Payment Act, there is no requirement that the third-party administrator pay the providers within that standard.

CAR staff also did not provide timely assistance responding to medical claim inquiries. The community care providers who stopped accepting NVC authorizations that the OIG interviewed stated they had a difficult time contacting VISN 6 CAR staff when they attempted to resolve their rejected claims or to obtain the status of a pending claim, including not receiving return calls after leaving voice messages with CAR. The CAR NVC Manager confirmed that community providers' voice messages were not always returned because they did not have enough call center staff to manage the volume.

Poor Service from Health Net in Resolving Choice Claims

Fourteen of the 15 community care providers stopped accepting Choice authorizations from January 2015 through July 2017.⁶ The OIG interviewed five of them and learned they did so primarily because they did not receive timely payment for their Choice claims. Health Net staff also did not provide timely assistance responding to their claim inquiries. Health Net's claims data indicated it approved 11,031 Choice claims for care provided from January 2015 through July 2017 for the 14 community care providers who stopped accepting Choice authorizations. The OIG's analysis of Health Net's claims data found it approved these claims in an average of 17 days, which was within the contractual goal "to process community provider claims within 30 calendar days of receipt of a clean claim." Although Health Net's data indicated it generally processed payments for these providers timely, this calculation includes only clean claims (claims that can be processed without obtaining additional information from the provider or third party), and did not account for delays that occurred when claims were rejected. The OIG identified multiple factors that contributed to providers' frustration in receiving payment for their unpaid Choice claims that potentially added time that was not included in Health Net's data, including claims that were rejected by the clearinghouse and claims that may have been processed inappropriately.

The first factor causing frustration was that providers were unaware of some rejected claims. Prior to Health Net staff processing an electronic claim, a clearinghouse received and reviewed these claims. Health Net stated the clearinghouse primarily rejected claims it determined did not contain sufficient information to identify the provider. Health Net stated they did not review or analyze whether the clearinghouse accurately rejected these claims, or whether they could identify the provider who submitted the claims. Health Net also stated it did not notify the community providers that their claims had been rejected because the clearinghouse did not provide sufficient information in the bulk rejection letters to allow them to generate a provider rejection letter. Furthermore, the OIG determined Health Net inaccurately approved 606 of 11,031 medical claims (about 5 percent) for \$0, as Health Net eventually paid a larger amount to the providers when it resubmitted their claims. In addition, the five community

⁶ These 14 community care providers include the five that stopped accepting only Choice authorizations, plus the nine providers who stopped accepting both NVC and Choice authorizations.

providers who stopped accepting Choice authorizations that the OIG interviewed stated they generally waited on hold for up to three to four hours to speak with Health Net staff to identify and resolve issues with unpaid claims, and that Health Net would discuss only three claims per call. Health Net's Call Center Director stated they were not contractually obligated to adhere to timeliness metrics for community provider calls, as they were for calls from veterans and VA.

Conclusion

At least 15 community providers stopped accepting NVC and Choice authorizations from January 2015 through July 2017, which affected the VAMC's ability to schedule VA patients for dermatology, neurosurgery, orthopedic, and urology services in the community. Based on interviews with OCC, the Fayetteville VAMC, and Health Net, the OIG determined these organizations did not effectively monitor community provider participation in the NVC and Choice Programs at the local level, and could not specifically identify how many community providers stopped accepting, or were accepting, authorizations for Fayetteville VAMC patients.

Community providers stopped accepting authorizations primarily because the VISN 6 CAR office and Health Net did not timely pay community care providers' medical claims, and did not effectively communicate with the providers in resolving unpaid claims. The OIG determined community providers who stopped accepting NVC authorizations waited, on average, about 46 days for CAR staff to process their claims that VA accepted in 2017. Health Net claims data indicated Health Net approved medical claims for the community care providers who stopped accepting Choice authorizations in about 17 days. However, the OIG determined the providers' frustration in resolving and receiving their unpaid Choice claims also stemmed from Health Net's clearinghouse, Change Healthcare, automatically rejecting some Choice claims and not notifying providers, and Health Net inaccurately approving Choice claims for \$0.

Prior to severing ties with VA, the nine providers who stopped accepting both NVC and Choice authorizations completed nearly 6,900 patient encounters with about 1,900 VA patients from January 2015 through July 2017. Based on VHA data, the Fayetteville VAMC provided care to over 72,500 patients in FY 2017, of which about 33 percent received care in the community. If VISN 6 CAR does not improve the timeliness of payments to community providers, and if VA staff and contractors do not effectively address community provider inquires, additional providers may stop accepting VA authorizations, presenting a risk of increased wait times and travel distances in other services as well.

What the OIG Recommended

In this report, the OIG made six recommendations to the Executive in Charge, Office of the Under Secretary for Health, to improve oversight of claims processing timeliness and monitoring of community provider participation.

Management Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with the OIG recommendations. The Executive in Charge provided acceptable action plans for each recommendation, with completion dates targeted for no later than August 2019. The OIG will monitor VHA's progress and follow up on the implementation of the recommendations until all proposed actions are completed.



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Abbreviations

CAR	Claims Adjudication and Reimbursement
FY	Fiscal Year
NVC	Non-VA Care
NVCC	Non-VA Care Coordination
OCC	Office of Community Care
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
VA	Department of Veterans Affairs
VAMC	Fayetteville, North Carolina Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

Objective

In July 2017, the OIG received an allegation that two orthopedic community providers associated with the Fayetteville, North Carolina, VA Medical Center (VAMC) stopped accepting Non-VA Care (NVC) and Veterans Choice Program (Choice) authorizations to provide care to VA patients.⁷ According to the complainants, this occurred because VA and Health Net Federal Services, LLC (Health Net) did not timely pay their medical claims. The OIG conducted this audit to determine whether community care providers associated with the VAMC stopped accepting NVC and Choice authorizations.

Fayetteville VAMC

According to the Veterans Health Administration (VHA), the Fayetteville VAMC provides medical, mental health, women's health, and specialty care services to veterans living in a 19-county area of southeastern North Carolina. Based on VHA data, the VAMC provided care to over 72,500 patients in FY 2017, of which about 33 percent received care in the community. The VAMC also provides primary care and mental health services through its six community based outpatient clinics, and primary care and specialty services through their two healthcare centers. The Fayetteville VAMC is one of seven medical centers in the VA Mid-Atlantic Health Care Network, also known as Veterans Integrated Service Network (VISN) 6.

The majority of veterans enrolled in the VA healthcare system receive care in VA medical facilities, such as the Fayetteville VAMC and its community based outpatient clinics. However, VA also has statutory authority to obtain healthcare services from NVC providers when services are not readily available from a VA medical facility.⁸ The Fayetteville VAMC offers community care services through NVC and Choice authorizations. The Office of Community Care (OCC) Claims Adjudication and Reimbursement (CAR) Data Team reported that, during FY 2017, the VAMC authorized NVC care for about 13,900 veterans at a cost of about \$64.5 million, and authorized Choice care for about 16,500 veterans at a cost of about \$31.8 million. The VHA's OCC CAR office located in Salem, Virginia, was responsible for processing all NVC medical claims submitted by community providers for VISN 6, including the Fayetteville VAMC.

⁷ The OIG determined that community providers were associated with the Fayetteville VAMC if the providers received their authorizations from Fayetteville VAMC staff.

⁸ Title 38, United States Code 1703; Title 38, Code of Federal Regulations §17.52.

VA Community Care

VA offers care in the community primarily through the NVC and Choice Programs, which are separate and have different eligibility criteria and different processes for referrals to providers and payment of claims.⁹ VA facilities may authorize patients to receive care in the community through the NVC Program when they do not have the necessary service available, the patient lives too far from a VA facility, or when the facility cannot see the patient timely. When VA staff authorized care in the community using NVC, schedulers with the VAMC Non-VA Care Coordination (NVCC) team coordinated with the veteran and the community care provider to schedule the veteran's appointment.

The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) further required VA to offer veterans an authorization to receive care in the community who are unable to secure an appointment at a VA medical facility within 30 days or who lived more than 40 miles from a VA facility.¹⁰ VA facilities began referring eligible veterans to non-VA, community providers using the Choice Program as of November 2014. When VA staff deemed patients eligible to obtain care in the community through Choice, NVCC staff at the VAMC electronically submitted an authorization and related medical documentation to a third-party administrator. Health Net was the third-party administrator responsible for managing Choice authorizations for VISN 6, including the Fayetteville VAMC.¹¹ Health Net was responsible for scheduling veterans' Choice appointments with community providers, and for paying community provider medical claims. A community provider is defined in the Health Net contract as a hospital, clinic, healthcare institution, healthcare professional, or group of healthcare professionals that provide healthcare services to veterans. Providers who completed care for Choice authorizations received payment directly from Health Net, which then sought reimbursement from VA. Health Net was required by contract to "provide a high-quality network, or networks, of individual and institutional providers." The contract specified, "the network, or networks, shall have a sufficient number, mix, and geographic distribution of qualified providers to provide the full scope of health care required by this contract for the regions awarded."

According to the VA Community Care Provider Toolkit from May 2017, VA's community care national network included more than 446,000 federal, private, and academic partners who delivered outpatient, inpatient, and extended care services to veterans. According to the OCC CAR Data Team, VA provided healthcare services to approximately one million veterans through the Choice Program, and nearly 740,000 veterans through the NVC Program, totaling

⁹ Patient-Centered Community Care (PC3) is another VA community care program, and is administered by the third-party administrator (Health Net). The OIG did not include PC3 claims in the scope of this audit because VHA data indicated that VA patients obtained care from the community providers discussed in this report almost exclusively by way of the NVC and Choice Programs during 2017.

¹⁰ *Veterans Access, Choice, and Accountability Act of 2014* (Public Law 113-146, August 7, 2014) was enacted to improve access to care from non-VA providers.

¹¹ Health Net's contract expires on September 30, 2018.

more than \$9 billion during FY 2017. Of this, the Fayetteville VAMC accounted for more than \$96.3 million of the total for veterans who obtained care through either the NVC or Choice Programs.

Providing Veterans with Community Care

During the scope of this audit, VA facilities authorized veteran patients to receive care in the community through the NVC and Choice Programs.¹² VA staff could refer veterans for care using the Choice Program based on specific eligibility parameters related to wait times for appointments and the veterans' distance from the nearest VA facility. This determination was based on the veteran's needs, provider availability, funding availability for the respective option, and whether the veteran met eligibility requirements for Choice.

¹² On June 6, 2018, the VA Mission Act of 2018 was signed into law [PL 115-182], consolidating VA's community care programs into one. VA will be responsible for making appointments and the legislation contains provisions relating to payment to providers. Recognizing that it will take an additional year to fully transition to the new consolidated program, Congress established a sunset date for the Choice Program a year after the enactment of the Mission Act. [PL 115-182, Section 143]

Figure 1 illustrates the process for veterans to obtain care through NVC and Choice.

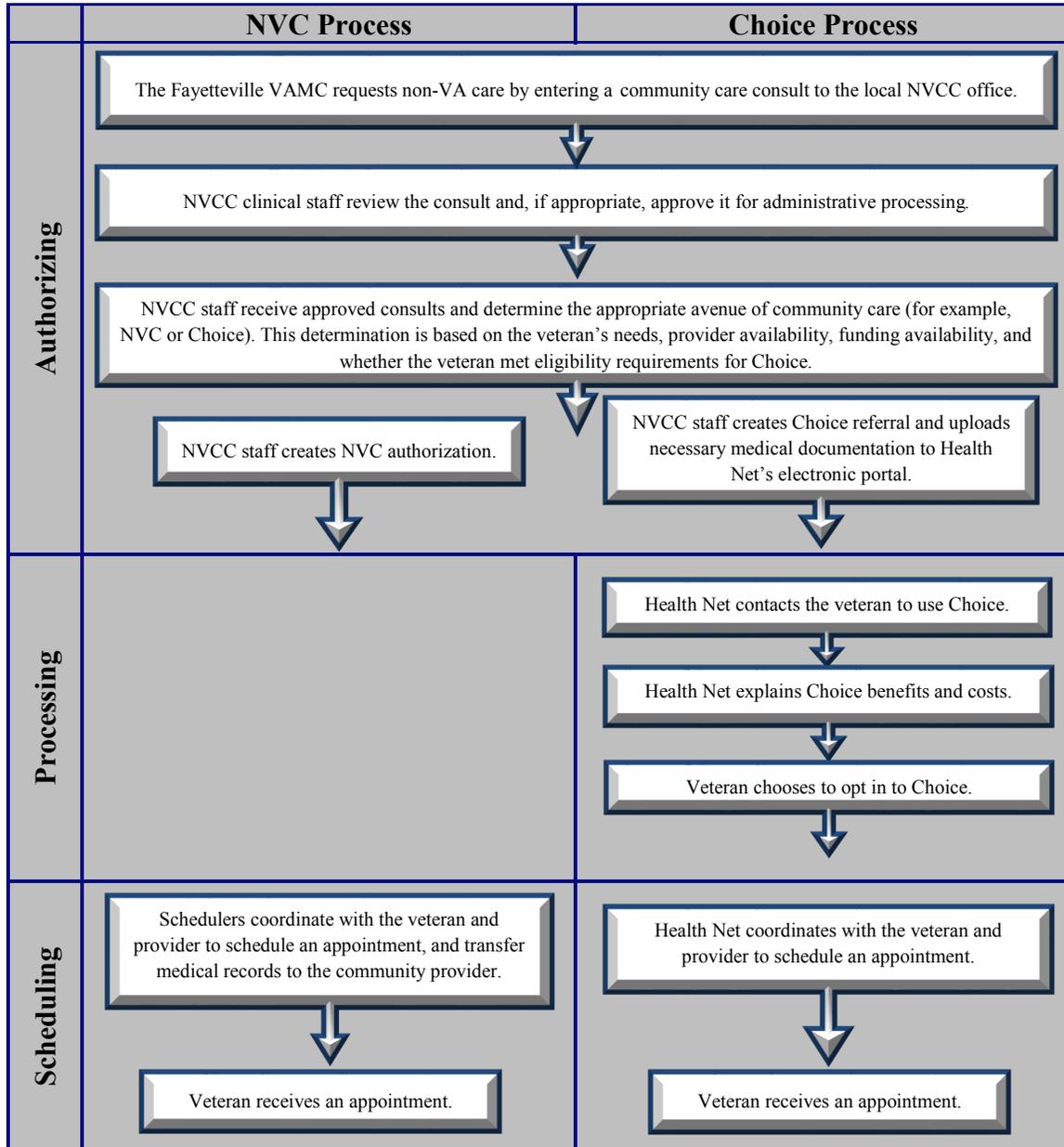


Figure 1. NVC and Choice Authorization and Scheduling Processes

(Source: *OIG summary of Choice First Standard Operating Procedure* dated June 2017, *OCC's Transition Field Guidebook* updated on March 2018, and *One Consult Standard Operating Procedures* dated October 2017)

Following completion of care, non-VA community care providers submitted claims to receive payment for their services. OCC was responsible for managing the NVC and Choice Programs at the national level. The Choice Act required VA to transfer authority to pay for hospital care, medical services, and other health care through community care providers from VISNs and

VAMCs to the OCC, effective October 1, 2014. OCC's CAR Directorate was responsible for processing community care claims.

NVC Claims Processing and Oversight Responsibilities

After the veteran attended the non-VA appointment as part of NVC, the community provider submitted applicable claims to VA's CAR staff for payment. CAR staff then reviewed the claims to determine whether they were eligible for reimbursement. When CAR staff approved the claims for payment, they released payment batches to VA's Financial Management System to process electronic fund transfer payments or checks to community providers. OCC's CAR Directorate was responsible for providing oversight over VISN 6 CAR claims processing. VISN 6 CAR staff were responsible for processing NVC claims submitted by community care providers, including those associated with the Fayetteville VAMC.

Choice Claims Processing and Oversight Responsibilities

Upon completion of a Choice care appointment, the community provider submitted applicable claims to Health Net for processing. A clearinghouse, Change Healthcare, received Choice claims that community providers submitted electronically. The clearinghouse rejected electronic claims when it could not identify the provider or when the claim was incomplete. The clearinghouse sent the claims it accepted to Health Net. Health Net's verification team received Choice claims that community providers submitted by mail and verified that claims were complete. Health Net rejected claims it determined to be incomplete or illegible. Health Net staff then verified whether the claims had an accurate authorization number, and whether the claim was eligible for reimbursement. Health Net staff reviewed, approved, and paid claims that were authorized and deemed eligible. Health Net staff denied claims they determined were ineligible.

A VA contracting officer's representative was responsible for ensuring Health Net adhered to specifications contained in the Health Net contract, which included monitoring Choice provider claims processing and payments. The contracting officer's representative was delegated by the contracting officer to ensure Health Net complied with the contract. According to the contract, Health Net "shall make payment to community providers for health care services in accordance with commercial standards with a goal to process community provider claims within 30 calendar days of receipt of a clean claim."¹³ Health Net was also required by contract to submit a weekly report of claims processing metrics, including the average number of days to pay claims, the number of claims processed, and the percentage and number of claims rejected and denied by reason. The contracting officer's representative was responsible for reviewing these reports and taking corrective action, when needed.

¹³ A "clean claim" is a claim that can be processed without obtaining additional information from the provider of service or from a third party.

Results and Recommendations

Finding: Some Community Care Providers Stopped Accepting Non-VA Care and Choice Program Authorizations

The OIG substantiated the specific allegation that two orthopedic community providers associated with the Fayetteville VAMC no longer accepted VA patients, and further determined that additional community providers also stopped accepting VA patients. Specific to the allegation, one orthopedic provider stopped accepting only NVC authorizations, and another orthopedic provider stopped accepting both NVC and Choice authorizations. Based on informal notes used by the VAMC NVCC schedulers, the OIG identified another 13 community providers who stopped accepting authorizations for VA patients from January 2015 through July 2017.

The community providers interviewed by the OIG cited issues with both VA and Health Net, and stated they stopped accepting VA authorizations primarily because the VISN 6 CAR office and Health Net did not timely pay community care providers' medical claims. Specifically, 11 of the 15 community providers stated they stopped accepting authorizations because they did not receive timely payments; the other four did not wish to provide additional information. Schedulers also stated community providers stopped accepting VA authorizations due to timely payment issues. In addition, community care providers noted that VA staff and Health Net did not provide timely assistance responding to claim inquiries, which also contributed to the providers' decision to stop accepting NVC and Choice authorizations. Fewer community provider options affected the VAMC's ability to schedule VA patients for dermatology, neurosurgery, orthopedic, and urology services in the community. Furthermore, VA paid interest as a result of delayed payments. If VISN 6 CAR does not improve the timeliness of payments to community providers, and if VA staff and contractors do not effectively address community provider medical claim inquiries, additional providers may stop accepting VA and Choice authorizations, presenting a risk of increased wait times and travel distances in other services as well.

What the OIG Did

The OIG interviewed VAMC and OCC personnel involved with NVC and Choice claims processing, contracting personnel who manage VA's Health Net contract, Health Net personnel, and local community care providers. To determine the timeliness of claim payments, the OIG obtained and analyzed recent VHA and Health Net claims data related to the 15 community providers who stopped accepting NVC authorizations, Choice authorizations, or both NVC and Choice authorizations. Specifically, the OIG analyzed data consisting of over 17,000 medical claims submitted by the 15 community providers from January 2015 through July 2017.

This finding discusses:

- Community care providers who stopped accepting some NVC and Choice authorizations,
- Community care provider participation not effectively monitored,
- Community care providers citing frustration with VA's claims processing, and
- Community care providers citing poor customer service from Health Net.

Community Care Providers Stopped Accepting Some Authorizations

The OIG interviewed key personnel from the OCC, the Fayetteville VAMC, and Health Net to identify the extent to which community providers stopped accepting NVC or Choice authorizations. Based on informal notes maintained by the VAMC schedulers, the OIG determined at least 15 community providers (including the two noted in the allegation) stopped accepting authorizations for VA patients from January 2015 through July 2017. Aside from these notes, the VAMC did not maintain records of which providers stopped accepting VA authorizations. The three organizations told the OIG they did not formally monitor community providers participating in or leaving the NVC or Choice Programs at the local level, and could not specifically identify how many community providers stopped accepting, or were accepting, authorizations for Fayetteville VAMC patients.

The OIG contacted the 15 community providers the VAMC believed no longer accepted VA authorizations to verify whether these providers stopped accepting only NVC authorizations, only Choice authorizations, or both NVC and Choice authorizations. Significantly, nine of the 15 providers stopped accepting both NVC and Choice authorizations, which meant veterans no longer had access to those providers by way of VA. These nine community care providers offered dermatology (one provider), neurosurgery (two providers), orthopedic (two providers), and urology (four providers) services to VA patients associated with the Fayetteville VAMC. Prior to severing ties with the VA from January 2015 through July 2017, these nine providers completed nearly 6,900 patient encounters with about 1,900 VA patients.¹⁴

In addition to the nine community care providers who stopped accepting both NVC and Choice authorizations, five continued to accept NVC authorizations but stopped accepting Choice authorizations from Health Net, and one continued to accept Choice authorizations but stopped accepting NVC authorizations from the VAMC.

¹⁴ VHA Directive 1230, *Outpatient Scheduling Processes and Procedures* (July 15, 2016) states, "An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

Table 1 describes the services provided by the 15 community care providers associated with the VAMC who stopped accepting authorizations.

Table 1. Specialty Care Service Areas

Community Provider Specialty Service Area	Stopped Accepting Both Types of Authorizations	Stopped Accepting Only Choice Authorizations	Stopped Accepting Only NVC Authorizations
Dermatology	1	0	0
Ear, Nose, and Throat	0	1	0
Neurology	0	1	0
Neurosurgery	2	0	0
Orthopedic	2	0	1
Pain Management	0	1	0
Urology	4	2	0
Total	9	5	1

Source: OIG analysis of community care provider information obtained from the VAMC

Of the 15 community providers the OIG contacted, six agreed to in-depth interviews with the OIG. The remaining nine provided general information, such as confirming they no longer participated in NVC and Choice but did not provide further information or agree to an interview. The six community care providers the OIG interviewed stated they continued to see VA patients on existing authorizations until patients exhausted their approved number of visits. For those providers who stopped accepting only NVC or only Choice authorizations, they stated they still accepted the other type of authorization because they wanted to continue providing care to veterans, and because they did not have as many challenges managing the other type of authorization. For example, one community provider, who stopped accepting only Choice authorizations, stated they encouraged veterans who were receiving care through the Choice Program to request an NVC authorization from the Fayetteville VAMC. As a result, veterans could potentially continue their care with the same provider.

Table 2 identifies the year these 15 community providers estimated they stopped accepting Choice and NVC authorizations.

Table 2. Year Providers Stopped Accepting Authorizations

Type of Authorization	2015	2016	2017	Unknown*	Totals**
Choice	3	3	6	2	14
NVC	3	2	4	1	10

Source: Community providers contacted by the OIG

** Three providers were unable to estimate the year they stopped accepting authorizations.*

***The "Totals" in this Table overlap, as the community care providers who stopped accepting both types of authorizations are included in each row, where applicable.*

While these six community providers voiced frustration over untimely payments and assistance in responding to medical claim inquiries, all expressed a desire to continue providing care to VA patients, but their dealings with VA and Health Net were taking too much time. Specifically, community providers stated they waited on hold for three to four hours to speak with Health Net staff to identify and resolve issues with unpaid claims, and that Health Net would discuss only three claims per call. For example, one neurosurgery provider stated that the clinic was investing too much time trying to obtain Health Net’s assistance in determining the status of their unpaid Choice claims, and in obtaining clarification on the claims that Health Net rejected. In addition, a radiology provider voiced frustration over having an outstanding claim from January 2016, being “forced to send a bill” to a VA patient, and waiting on hold for more than two hours to speak with Health Net to obtain the status of a claim.

Community Provider Participation Not Effectively Monitored

Based on interviews with OCC, the Fayetteville VAMC, and Health Net, the OIG determined these organizations did not effectively monitor community provider participation in the NVC and Choice Programs at the local level, and could not specifically identify how many community providers stopped accepting, or were accepting, authorizations for Fayetteville VAMC patients. An OCC program analyst stated that VAMCs were responsible for monitoring community provider participation in their NVC Program, and that Health Net was to track provider participation in the Choice Program. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures* (July 15, 2016), stated that the facility director is responsible for ongoing review of access to care indicators.

Health Net is required by contract to “provide a high-quality network, or networks, of individual and institutional providers, which may include academic medical centers and regional networks for specialty and primary care services.” The contract specifies, “The network, or networks, shall have a sufficient number, mix and geographic distribution of qualified providers to provide the full scope of health care required by this contract for the regions awarded.” A VHA OCC

program manager stated that Health Net provided OCC a nationwide list of network providers monthly to observe whether the number of providers significantly changed nationwide. However, Health Net stated they did not generally remove community providers from their information if they stopped accepting Choice authorizations.

Fayetteville VAMC's Awareness of Community Provider Availability

The OIG determined the VAMC did not effectively monitor provider participation or availability for community care services. The VAMC NVCC management and staff provided three estimates of the number of community providers for all services that were accepting NVC authorizations from the VAMC.

- In early October 2017, NVCC management and staff estimated, based on information obtained from the NVCC schedulers, that there were about 200 community care providers associated with the Fayetteville VAMC that accepted NVC authorizations.
- Later in October 2017, NVCC management estimated there were about 800 community providers in the area that accepted NVC authorizations, although the source of this information was not provided.
- In April 2018, NVCC management and staff provided the OIG a spreadsheet, based on lists informally tracked by the schedulers, that contained about 520 community providers they stated were accepting NVC authorizations.

The VAMC NVCC schedulers informally tracked community provider participation in the NVC Program to assist them with scheduling veterans for community care appointments, but they did not always notify NVCC leadership when they identified a community provider who stopped accepting NVC authorizations. Instead, a Fayetteville VAMC NVCC scheduling supervisor and three schedulers stated they generally removed these providers from their own lists of available community providers for the service they scheduled. The schedulers stated they continued to pursue scheduling an appointment by identifying from their lists the next closest available community provider to the veteran. If the scheduler determined the next closest option was too far for the veteran to travel, or did not provide the specific service the veteran needed, they said they conducted internet searches for providers near the veterans' address and called the providers to ask if they would accept VA patients through the NVC Program.

The Fayetteville VAMC NVCC schedulers stated they had challenges scheduling VA patients for dermatology, neurosurgery, orthopedic, and urology services in the community, and often had to schedule these veterans with providers who were further away from their home. The Fayetteville VAMC did not effectively assess whether it had access to a sufficient network of providers in the Fayetteville, North Carolina, area. As the facility director is responsible for ongoing review of access to care indicators, it is important for the VAMC to know what services may lack a sufficient network of community providers as they consider how to provide quality and timely care for their patients.

Recommendation 1 addresses the need for VHA to ensure community care provider participation is effectively monitored at the local level to mitigate the risk that unidentified gaps in specialty care coverage may increase veteran wait times and driving distances.

Impact That Loss of Providers had on Fayetteville VAMC's and Health Net's Ability to Schedule Appointments

The Fayetteville VAMC NVCC Chief and the NVCC schedulers stated it was difficult to schedule VA patients for dermatology, neurosurgery, orthopedic, and urology services in their community. The OIG determined the VAMC had access to only three community providers who accepted NVC authorizations in Fayetteville, North Carolina, for these four services, and in many instances, the schedulers had to schedule appointments with community care providers in the surrounding areas outside of Fayetteville. Similarly, Health Net schedulers stated they had a difficult time scheduling veterans' Choice appointments for dermatology, neurology, orthopedic, urology, and pain management services. VAMC and Health Net schedulers stated they conducted internet searches to identify community providers near the veteran's home when they did not have established local options. However, the VAMC schedulers stated that it was difficult to identify new community providers willing to accept authorizations.

The OIG interviewed the four Fayetteville NVCC schedulers responsible for scheduling veterans for dermatology, neurosurgery, orthopedic, and urology care in the community.

- The NVCC scheduler responsible for scheduling dermatology appointments stated that since she started scheduling dermatology appointments in November 2016, no dermatology providers in Fayetteville accepted NVC authorizations. The dermatology provider referenced in Table 1 has a location in Fayetteville, but stopped accepting NVC authorizations in 2015. The scheduler stated most of the VAMC patients lived in Fayetteville; however, the next closest available dermatology providers were located about 50 minutes from Fayetteville.
- The NVCC scheduler responsible for scheduling neurosurgery appointments stated there was currently only one provider in Fayetteville who accepted NVC authorizations, and the next closest neurosurgery provider was located in Pinehurst, North Carolina, which is about one hour from Fayetteville. The VAMC Chief of Staff also acknowledged they did not have sufficient access to a neurosurgery provider network and had to schedule neurosurgery patients for care in Durham, North Carolina, or Chapel Hill, North Carolina, which are about an hour and a half away from Fayetteville. The lack of neurosurgery options was particularly important because the VAMC NVCC Chief stated the VAMC did not provide neurosurgery care at the VAMC.
- The NVCC scheduler responsible for scheduling orthopedic appointments stated there was now only one orthopedic provider in Fayetteville who accepted NVC authorizations.

The scheduler stated the next two closest orthopedic providers who accepted NVC authorizations were located about forty minutes to one hour away from Fayetteville. The scheduler also explained they had to schedule some veterans, including cancer patients and patients with spine issues, for appointments with providers located one to two hours from Fayetteville because those specific services were not provided within an hour from Fayetteville.

- The NVCC scheduler responsible for scheduling urology appointments stated there was now only one urology provider in Fayetteville who accepted NVC authorizations and the next closest urology provider was about 30 minutes away from Fayetteville.

The Health Net schedulers stated they would conduct an internet search for applicable providers close to the veteran's home when they learned a community provider had stopped accepting Choice authorizations. As with the VAMC schedulers, Health Net schedulers also stated it was difficult to schedule dermatology, orthopedic, and urology appointments for VA patients. The Health Net contract required Health Net to schedule an appointment within 15 business days of receipt of the Choice authorization, and to return any unscheduled authorizations to VA on the 16th business day. Health Net returned about 7,700 Choice authorizations to the Fayetteville VAMC from January 2017 through July 2017. Of those, about 35 percent were authorizations for dermatology, neurosurgery, orthopedic, and urology services. When the VAMC NVCC staff received the returned Choice authorizations, the NVCC Chief stated the VAMC would then authorize the veteran for care through the NVC Program, submit another Choice authorization to Health Net, or attempt to see the patient at the VAMC. All of these actions ultimately resulted in longer wait times for veterans to receive care.

As a result of some providers no longer accepting authorizations, VA and Health Net schedulers encountered challenges in scheduling VA patients for care in the community, which led to increased driving distances to reach NVC or Choice providers and longer wait times.

Community Care Providers Cite Frustration with VA's Claims Processing

Ten of the 15 community care providers stopped accepting NVC authorizations from January 2015 through July 2017.¹⁵ These 10 providers offered dermatology, neurosurgery, orthopedic, and urology services.

The OIG interviewed three of them and learned they did so for two primary reasons:

- VA did not timely process their medical claims.

¹⁵ These 10 community care providers include the one who stopped accepting only NVC authorizations, plus the nine providers who stopped accepting both NVC and Choice authorizations.

- The VISN 6 CAR staff did not provide timely assistance responding to their medical claim inquiries.

VA Did Not Timely Process NVC Claims

For the 10 community providers who stopped accepting NVC authorizations, CAR approved 2,263 NVC medical claims from January 2015 through July 2017. From January 2017 through July 2017, CAR staff approved 336 medical claims for those community providers in an average of 46 days.¹⁶ The community care providers the OIG interviewed stated they continued to see VA patients on existing authorizations until patients exhausted their approved number of visits; therefore, these providers may have submitted claims after they decided to stop accepting authorizations. As shown in Table 3, the average time for VISN 6 CAR to approve NVC claims increased from 2015 to 2017.

Table 3. Average Days for VISN 6 CAR to Approve NVC Claims

Approved for Payment	2015	2016	2017
Number of Claims Approved by CAR	1,241	685	336
Average Days to Approve	19	40	46
Percent Approved after 30 Days	15%	45%	76%

Source: OIG analysis of VISN 6 CAR approved time of NVC claims

In comparison to VISN 6 CAR’s average 46-day approval time during 2017, CAR staff nationwide approved claims in an average of 33 days during the same period.¹⁷

VA’s payment of medical claims to community providers for NVC claims is governed by the Prompt Payment Act, which requires VA to make payment within 30 days of receipt of the claim.¹⁸ From January 2015 through July 2017, VISN 6 CAR had an average of about 143,200 unprocessed claims per day in their inventory, including about 53,300 claims (just over 37 percent) that were pending over 30 days. During this period, VA paid about \$156,000 in interest for claims associated with the Fayetteville VAMC that VISN 6 CAR staff did not pay within 30 days.

¹⁶ Eight of the 10 community providers had claims approved during this specific period; the other two providers did not have claims approved in this time frame.

¹⁷ Nationwide calculation of days based on OIG analysis of data obtained from VHA Support Services Center reporting of VA’s Fee Basis Claims System.

¹⁸ While the Choice contract requires that VA pay the third-party administrator within the timeliness standard imposed by the Prompt Payment Act, there is no requirement that the third-party administrator pay the providers within that standard.

VISN 6 CAR Office Did Not Meet Demand of Incoming NVC Claims

During FY 2017, CAR staff received, on average, about 90,600 NVC claims per month, and processed, on average, about 85,500 claims per month. As of December 2017, VISN 6 CAR had about 159,000 unprocessed claims, including about 48,600 that were already older than 30 days.

Based on staffing information provided by the CAR NVC Manager, VISN 6 CAR had 56 claims examiners as of September 2017. CAR staff provided claims examiners' performance standards that included OCC production goals. Based on the production standards for an eight-hour work day, claims examiners were expected to process at least 78 claims per day.¹⁹ Based on this standard, the OIG determined that CAR had enough staff to process at least 91,700 claims per month. Furthermore, the OIG determined that if CAR claims examiners met their production goals and processed about 91,700 claims per month, they would reduce their backlog of claims over 30 days by about 1,100 claims per month.

The CAR NVC Manager stated they were not able to meet the production goals because they did not use all of their claims examiners exclusively to process claims. Specifically, the CAR NVC Manager stated that claims examiners also had to manage other related work, such as scanning in claims, indexing medical records, and responding to appeals and congressional inquiries. According to the CAR NVC Manager, in March 2016, the Director of OCC's CAR authorized, via email, CAR staff to work overtime to process claims. Although the CAR NVC Manager stated she believed the overtime was helpful, they did not specifically monitor the effect this extra processing time had on reducing their backlog of claims.

Recommendation 2 addresses the need for VHA to ensure the VISN 6 CAR office determine the appropriate number of staff needed to process outstanding and incoming claims, and ensure they consistently dedicate sufficient staff to timely process NVC medical claims.

Inaccurately Rejected Claims Added to Delays in Paying Providers

As of September 2017, CAR staff rejected 1,570 claims submitted by the 10 community providers for care they provided from January 2015 through July 2017. The OIG did not assess the accuracy of all 1,570 rejected claims, but did assess 393 claims that CAR rejected as "duplicate" claims. The OIG determined that CAR staff inaccurately rejected 159 of 393 claims (about 40 percent) as duplicates.

CAR staff inaccurately rejected these particular claims for two general reasons. For 57 claims, CAR staff rejected the provider's initial claim submission erroneously as a duplicate after receiving a subsequent claim for the same episode of care. According to the Fee Basis Claim System User Manual, in the case of a potential duplicate, CAR staff must either reject the new claim or provide justification for allowing the new claim to be processed. The CAR NVC

¹⁹ The OIG did not assess the appropriateness of OCC's production goals in this audit.

Manager stated that the claims examiners should have processed the initial claim and rejected the subsequent claim. By processing the latter claims, CAR's claim processing timeliness appeared shorter.

Example 1

A provider of orthopedic services submitted a claim in March 2016. They had not received payment, so they submitted the claim again in April 2016. CAR staff inaccurately rejected the first claim from March 2016 as a duplicate and approved the April 2016 claim for payment in June 2016, showing a processing time of 57 days. However, the provider actually waited 83 days to receive payment from the time they initially submitted their claim.

For 102 claims, CAR staff rejected the providers' resubmitted claims erroneously as a duplicate after the initial claim submission was already rejected for various reasons. When CAR staff reject a claim, they send a letter to the provider that explains why their claim was rejected so the provider can resubmit a corrected claim. However, when the providers resubmitted these 102 claims—whether they made appropriate corrections or not—CAR erroneously rejected the claims as a duplicate. The OIG determined this rejection reason was not accurate, as there were no open claims at the time of the second submission. This is important because the provider would have received a letter indicating CAR rejected their claim because it was a duplicate, and would not have indicated to the provider what they needed to address, if anything, in order for their claim to be approved.

Example 2

A provider of dermatology services submitted a claim in August 2015. CAR staff scanned this claim into their system on August 27, 2015, and rejected it on August 31, 2015, because it did not contain separate procedure codes. The provider resubmitted the claim on December 17, 2015. CAR staff rejected the claim as a duplicate on January 7, 2016; however, this was inaccurate because there were no open claims at the time of this resubmission. The provider resubmitted the claim a third time on February 24, 2016. This time, CAR staff approved the claim for payment on March 31, 2016, which indicated a CAR processing time of about 36 days. The provider actually waited about 105 days from the second claim submission on December 17, 2015.

As of May 2018, CAR staff subsequently approved 36 of the 159 inaccurately rejected claims.²⁰ CAR staff processed those 36 claims in an average of 49 days from the resubmission date. However, when factoring in the additional time the providers waited due to inaccurate rejections

²⁰ The remaining claims were either never resubmitted by the providers, were subsequently rejected for another reason, or CAR staff had not processed a resubmitted claim as of May 2018.

by CAR, providers waited, on average, 130 days to receive payments for those services. This is important because it appeared to VHA leadership that claims were processed more timely than they actually were. In addition, providers were not aware of what they needed to supply in order to receive payment because CAR rejected their claims for an inaccurate reason.

According to the CAR NVC Manager, their local CAR office did not have the resources available to conduct routine reviews of rejected claims. CAR had quality assurance staff, but stated their process was to generally conduct quality reviews when they identified potential concerns, such as a significant change in processing or rejection rates. In addition, the CAR NVC Manager stated the OCC CAR Directorate did not conduct routine reviews of their claims.

Recommendation 3 addresses the need for VHA to ensure the VISN 6 CAR office implements specific controls to ensure CAR staff are not inaccurately rejecting NVC claims, or rejecting claims for the wrong reasons.

Ineffective Communication by VA

Five of the six community care providers the OIG interviewed stated they had a difficult time contacting VISN 6 CAR staff when they attempted to resolve their rejected claims or obtain the status of a pending claim, including not receiving return calls after leaving voice messages with CAR staff. For example, one of these five community providers stated they generally had to leave a voice message for VISN 6 CAR staff when they inquired about claims, but their calls were never returned. The other community care provider did not express concerns regarding ineffective communication with CAR staff.

The CAR NVC Manager confirmed that community providers' voice messages were not always returned by VISN 6 call center staff. The CAR NVC Manager stated the call center had only six staff who were responsible for answering the phone and returning voice messages from community providers, and she said that six staff were not enough to manage the call volume. Furthermore, the CAR NVC Manager stated that some voice messages were never retrieved because they were automatically deleted after 10 days, or when the mailbox was full.

According to the CAR NVC Manager, as of September 2017, community providers associated with the VAMC were able to get assistance with their NVC medical claim inquiries from a new centralized call center. The CAR NVC Manager said this centralized call center would be responsible for managing incoming calls from community providers related to their NVC claims.

Recommendation 4 addresses the need for OCC to implement controls to ensure VA staff timely resolve medical claim inquiries from community providers.

Community Care Providers Cite Poor Customer Service from Health Net

Fourteen of the 15 community care providers stopped accepting Choice authorizations from January 2015 through July 2017.²¹ The OIG interviewed five of them and learned they did so primarily because they did not receive timely payment for their Choice claims. Health Net staff also did not effectively communicate with them and provide timely assistance responding to their claim inquires. Specifically, community providers stated they waited on hold for three to four hours to speak with Health Net staff to identify and resolve issues with unpaid claims, and that Health Net would discuss only three claims per call. Health Net's contract did not require them to meet specific timeliness measures when responding to community provider calls.

Health Net was responsible for timely paying community care providers' medical claims for Choice authorizations associated with VA facilities in VISN 6. Health Net's claims data indicated it approved 11,031 Choice claims submitted by the 14 community providers for care they provided from January 2015 through July 2017. Based on the OIG's assessment of Health Net's claims data, it approved these claims in an average of 17 days, and about 88 percent were approved within 30 days.²² Health Net's contract states it "shall make payment to community providers for health care services in accordance with commercial standards with a goal to process community provider claims within 30 calendar days of receipt of a clean claim."

Although Health Net's data indicated it generally processed payments for these providers within 30 days, this calculation includes only clean claims, and did not account for delays that occurred when claims were rejected. The OIG identified the following factors that contributed to providers' frustration in resolving and receiving payment for their unpaid Choice claims that potentially added time that was not included in Health Net's data.

- Health Net's clearinghouse, Change Healthcare, automatically rejected Choice claims it determined did not contain sufficient information to identify the provider. However, community providers were not notified of the rejection.
- Health Net did not always pay the correct community providers from January 2015 through March 2016, because claims examiners were not trained on how to identify the correct mailing address.
- Health Net inaccurately approved Choice claims for \$0.

²¹ These 14 community care providers include the five that stopped accepting only Choice authorizations, plus the nine providers who stopped accepting both NVC and Choice authorizations.

²² This calculation includes only clean claims (claims that can be processed without obtaining additional information from the provider or third party), and consists of the time from one claim submission until that same claim submission was approved. The calculation did not account for delays that occurred when claims were rejected.

Providers Unaware Health Net’s Clearinghouse Rejected Some Choice Claims

Prior to Health Net staff processing an electronic claim, a clearinghouse, Change Healthcare, received and reviewed these claims. This was an automated process in which the clearinghouse either rejected the claim, or provided the claim to Health Net for processing. Health Net stated the clearinghouse rejected claims it determined did not contain sufficient information to identify the provider. Health Net also stated the clearinghouse did not notify community providers when it rejected claims for this reason. Instead, the clearinghouse provided bulk rejection letters to Health Net for its review. A bulk rejection letter was a notification to Health Net containing numerous rejected claims. For example, Health Net stated they received a list of 804 rejected claims from the clearinghouse on a single day in October 2017. However, Health Net stated it did not review or analyze whether the clearinghouse accurately rejected these claims, or whether they could identify the provider who submitted the claims. Furthermore, Health Net stated it did not notify the community providers that their claims had been rejected because the clearinghouse did not provide sufficient information in the bulk rejection letters to allow them to generate a provider rejection letter. This is important because community providers were not aware that some of their claims had been rejected.

The VA contracting officer reported that Health Net submitted a weekly report to VA that included the percentage and number of claims rejected and denied by reason, as required by contract. However, Health Net stated it did not include claims rejected by the clearinghouse in the timeliness data reported to VA because it could not identify the Choice claims the clearinghouse rejected, nor did it review these claims to determine whether it could have identified the provider.

Recommendation 5 addresses the need for VHA to implement oversight procedures to ensure community care contractors effectively notify providers when they reject their claims.

Health Net Made Payments to Incorrect Providers During 2015–2016

Health Net staff stated they did not always pay the correct community providers from January 2015 through March 2016. Health Net staff stated this occurred because claims examiners were not trained on how to identify the correct billing address, and they did not identify this error until about one year later. Health Net stated it did not have a method for identifying these payment errors, and instead learned of these errors from community providers who received payment for other providers’ claims. As of October 2017, Health Net stated it was still correcting these payment errors. Two of the community providers the OIG interviewed stated they had experienced instances where Health Net took over a year to pay claims; however, it was not known whether their delayed payments were attributable to this specific issue. Health Net could

not produce data to determine whether this issue specifically affected the 14 community care providers identified in this audit who stopped accepting Choice authorizations.

Health Net Approved Claims for \$0

The OIG determined Health Net approved 634 of 11,031 medical claims for \$0. Health Net stated it approved Choice claims for \$0 in instances such as when the primary insurance carrier pays more than the Medicare Allowed Amount, or when billed services are bundled. Despite these reasons, the OIG determined that Health Net inaccurately approved 606 of 11,031 medical claims (about 5 percent) for \$0, as Health Net eventually paid a larger amount to the community providers when they resubmitted claims for the same services.

When Health Net approved claims for \$0, community providers continued requesting actual payments for these services. The OIG determined these inaccurately approved claims likely caused community providers to spend additional time and resources contacting Health Net to determine why their claims were approved for \$0, before ultimately resubmitting them to Health Net to process again. The following example depicts an instance in which Health Net approved a claim for \$0, and how long a community provider actually waited to receive payment for the same episode of care.

Example 3

One pain management community provider initially submitted a claim to Health Net in January 2016 for \$683. Health Net paid this claim in March 2017, about 430 days after it was initially submitted. Health Net data showed the provider resubmitted the claim three times for this same encounter. The first submission was approved for \$0, the second submission was received in May 2016 and approved for \$0, and the third submission was received in March 2017 and approved for \$116.²³ While Health Net data showed it processed these three claims submissions in an average of about 16 days, the community provider waited about 430 days to receive payment.

Ineffective Communication by Health Net

The five community providers who stopped accepting Choice authorizations that the OIG interviewed stated they generally waited on hold for up to three to four hours to speak with Health Net staff to identify and resolve issues with unpaid claims, and that Health Net would discuss only three claims per call. The community providers stated they had to call back if they had questions on more than three claims. Community providers told the OIG that the time spent following up with Health Net on outstanding claims was not a cost-effective use of their

²³ The amount VA paid was less than the billed amount because VA payments are required to be adjudicated through a tiered system of Medicare rates, local VA Fee Schedule, and vendor charges.

resources. For example, one community provider reported they invested so much staff time trying to receive payment, they decided it would be more cost effective to write off the Choice claims. Another community provider stated they spent more money on employee salary to resolve Choice claims than the claims were worth. Another community provider stated they had one employee call Health Net in the morning to start waiting on hold, and then a second employee would take a turn waiting on hold. This provider explained that it occasionally took five hours before Health Net answered the phone. Health Net's untimely and ineffective communication contributed to the community providers' decision to stop accepting Choice authorizations.

Health Net's Call Center Director stated, and the OIG confirmed based on the contract, that Health Net was not contractually obligated to adhere to timeliness metrics for community provider calls, as it was for calls from veterans and VA. Health Net's Call Center Director stated that Health Net did accept incoming calls from community providers, but those calls were not a high priority. The Call Center Director confirmed that providers were limited to discussing three claims per call, and acknowledged that providers may have waited on hold more than an hour during certain times.

Recommendation 6 addresses the need for VHA to implement oversight procedures to ensure community care contractors effectively resolve medical claim inquiries from community providers.

Conclusion

At least 15 community providers stopped accepting NVC and Choice authorizations from January 2015 through July 2017. The OIG determined nine community care providers associated with the VAMC stopped accepting NVC and Choice authorizations. Six additional community care providers stopped accepting one type of authorization. This occurred primarily because the VISN 6 CAR office and Health Net did not timely pay community care providers' medical claims, and did not effectively communicate with the providers in resolving unpaid claims. The OIG determined 10 community providers waited, on average, about 46 days for CAR staff to process their NVC claims that VA accepted in 2017. Health Net claims data indicated Health Net approved medical claims for 14 community care providers in about 17 days. However, the OIG determined the providers' frustration in resolving and receiving their unpaid Choice claims also stemmed from Health Net's clearinghouse, Change Healthcare, automatically rejecting some Choice claims and not notifying providers, and Health Net inaccurately approving Choice claims for \$0.

Fewer community provider options affected the VAMC's ability to schedule VA patients for dermatology, neurosurgery, orthopedic, and urology services in the community. Based on interviews with OCC, the Fayetteville VAMC, and Health Net, the OIG determined these organizations did not effectively monitor community provider participation in the NVC and

Choice Programs at the local level, and could not specifically identify how many community providers stopped accepting, or were accepting, authorizations for Fayetteville VAMC patients. Furthermore, VA paid interest as a result of delayed payments. If VISN 6 CAR does not improve the timeliness of payments to community providers, and if VA staff and contractors do not effectively address community provider medical claim inquiries, additional providers may stop accepting VA and Choice authorizations, presenting a risk of increased wait times and travel distances in other services as well.

Recommendations 1–6

1. The Executive in Charge, Office of the Under Secretary for Health, ensure community care provider participation is effectively monitored at the local level to mitigate the risk of unidentified gaps in specialty care coverage.
2. The Executive in Charge, Office of the Under Secretary for Health, ensure the Veterans Integrated Service Network 6 Claims Adjudication and Reimbursement office identify and dedicate the appropriate number of staff needed to timely process Non-VA Care medical claims.
3. The Executive in Charge, Office of the Under Secretary for Health, ensure the Veterans Integrated Service Network 6 Claims Adjudication and Reimbursement office implements specific controls to ensure staff are not inaccurately rejecting Non-VA care claims, or rejecting claims for the wrong reasons.
4. The Executive in Charge, Office of the Under Secretary for Health, implement controls to ensure VA staff timely resolve medical claim inquiries from community providers.
5. The Executive in Charge, Office of the Under Secretary for Health, implement oversight procedures to ensure community care contractors effectively notify community providers when they reject their claims.
6. The Executive in Charge, Office of the Under Secretary for Health, implement oversight procedures to ensure community care contractors effectively resolve medical claim inquiries from community providers.

Management Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with the recommendations and stated VHA has incorporated them into the future of the organization and the community care program. The Executive in Charge provided action plans for each recommendation, with completion dates targeted for no later than August 2019.

To address Recommendation 1, the Executive in Charge reported that VHA will measure and monitor network adequacy through a new provider profile Information Technology tool and by conducting regular and interactive meetings. VHA will also include language in its Community

Care Network Request for Proposal that will require contractors to conduct monthly network adequacy meetings with VAMCs and VA stakeholders.

To address Recommendation 2, the Executive in Charge reported that VHA will continue increasing claims processing staff support to ensure timelier processing of non-VA care medical claims, and have created a staffing and workload model for claims processing that will enable better planning.

To address Recommendation 3, the Executive in Charge reported that OCC standardized rejection and denial reason codes, developed reports to flag the use of non-standardized reason codes, and will review and analyze these reports to ensure claims are being correctly adjudicated. Furthermore, OCC will standardize and improve the claims processing quality assurance process, and will create quality review criteria along with an Internal Review Standard Operating Procedure that will be provided to the field.

To address Recommendation 4, the Executive in Charge reported that VHA implemented metrics to gauge use, handling time, and other aspects of customer service. The Executive in Charge also reported that they have expanded the VA Call Center, and will work closely with providers to ensure they have access to VA's Vendor Inquiry System for self-service.

To address Recommendation 5, the Executive in Charge reported that VHA will include language in the Community Care Network Request for Proposal that will require contractors to always return claims, other than clean claims, to the community provider with a clear explanation of deficiencies within 30 days of original receipt.

To address Recommendation 6, the Executive in Charge reported that VHA will include performance requirements and standards related to a Provider Call Center in the Community Care Network Request for Proposal, and will require contractors to provide a monthly report summarizing their call center inquiries, performance metrics, open issues, and trends.

OIG Response

VHA's planned corrective actions are responsive to the recommendations and issues identified in this report. The OIG will monitor VHA's progress and follow up on the implementation of the recommendations until all proposed actions are completed. Appendix B includes the full text of VHA's comments.

Appendix A: Scope and Methodology

Scope

The OIG conducted this audit from August 2017 through July 2018. The audit focused on evaluating the timeliness of NVC and Choice claim payments made to community providers involved in those programs. To determine the timeliness of claim payments, the OIG obtained and analyzed recent VHA and Health Net claims data related to the 15 community providers who stopped accepting NVC authorizations, Choice authorizations, or both NVC and Choice authorizations. Specifically, the OIG analyzed data consisting of over 17,000 medical claims submitted by these 15 community care providers from January 2015 through July 2017.

Methodology

The OIG reviewed laws, VA memos, VHA directives, Health Net reference materials, and the Health Net contract as they related to NVC and Choice authorizations. The OIG interviewed contracting personnel who manage VA's Health Net contract. The OIG also conducted site visits to the following locations to interview facility leaders and staff involved with NVC and Choice claims processing, observe the claims review and approval processes, and interview local community care providers.

- Fayetteville, North Carolina, VA Medical Center
- Six community care facilities located in the Fayetteville, North Carolina, area
- The VISN 6 OCC CAR office located in Salem, Virginia
- Health Net's claims processing center located in Rancho Cordova, California

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by taking actions such as:

- Performing an assessment to identify fraud indicators and the likelihood of their occurrence
- Interviewing non-VA community providers, VHA, and Health Net staff concerning potential fraudulent activities within the scope of the objective
- Identifying applicable laws and regulations within the scope of the objective to be alert to any potential fraudulent activities

The OIG did not identify any instances of fraud during this audit.

Data Reliability

The OIG used computer-processed data received from the VISN 6 OCC CAR office and Health Net. To assess the reliability of the NVC claims data that CAR staff provided from the Fee Basis Claims System, the OIG compared the claims history data obtained by the OIG statistician to VA's Corporate Data Warehouse. The OIG did not identify any errors, and concluded the NVC claims data received were sufficiently reliable to meet the audit objectives and support the findings and recommendations.

To assess the reliability of Choice claims data provided by Health Net, the OIG compared these data to claims data the OIG obtained from VA's Fee Payment Processing System and Plexis Claims Manager. The OIG did not identify any errors in the reviewed approved claim information, such as claim status and authorized payment value. However, the OIG was not able to assess the reliability of Health Net's Choice claims receipt and processing dates because VA did not have access to these data. As a result, the OIG did not use these data as the basis for any conclusions. The OIG concluded the approved claims data received were sufficiently reliable to meet the audit objective and support the findings.

Government Standards

The OIG's assessment of internal controls focused on those controls relating to the audit objective. The OIG conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objective. The OIG concluded the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objective.

Appendix B: Management Comments

Department of Veterans Affairs Memorandum

Date: August 29, 2018

From: Executive In Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Allegation that Community Care Providers No Longer Accepted VA Authorizations, Fayetteville, NC (VIEWS 00098190)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on the Office Inspector General (OIG) draft report Allegation that Community Care Providers No Longer Accepted VA Authorizations, Fayetteville, NC. I concur with recommendations 1 through 6 and have already incorporated them into the future of the organization and the Community Care program.
2. Network adequacy and particularly the need to monitor local level network adequacy, is paramount to ensuring that each Department of Veterans Affairs (VA) Medical Center's community provider inventory is built around clinical and Veteran needs. To that end, the VA, along with the Community Care Network (CCN) Contractors will measure and monitor network adequacy through an approach that will include regular and interactive meetings and a new provider profile information technology tool. This approach and other improvements VA is planning will ultimately ensure local and national VA staff have enhanced access and information on the entire nation-wide community care provider base and within each VA region.
3. Since January 2018, the VA Office of Community Care (OCC) has been increasing claims processing staff support to ensure timelier processing of non-VA care medical claims. OCC's claims backlog peaked in June 2018, at 1.078 million but has been reduced by 215,000 claims since then. With the additional staff support, further improvements will occur over time. VA is targeting June 2019, for meeting the Mission Act-directed timeliness standard of processing a clean electronic claim within 30 days and clean paper claim processing within 45 days of receipt.
4. OCC is taking several steps towards ensuring that claims are being correctly adjudicated by staff. Starting August 2018, VA will implement a monthly review of newly created reports that will identify when non-standardized denial/rejection reasons are used and will work with staff to address identified issues. In addition, OCC has also begun to standardize and improve the claim processing quality assurance process. OCC is creating quality review criteria along with an Internal Review Standard Operating Procedure that will be provided to the field. The use of specifically defined quality review criteria will ensure that adjudication data will be collected, trended and analyzed on a variety of errors, including the application of incorrect rejection/denial reasons. Review and discussion of this information with field supervisors and staff will focus on identifying and initiating further corrective actions to address negative and inappropriate trends.
5. VA currently has several different channels community providers use to submit medical claim inquiries. These different channels are available to ensure providers can access information via self-service portals as well as with a live customer service representative. For each of these channels, VA works to ensure that there is a process in place to track both the receipt of the inquiry and its resolution. The MISSION Act requires VA either pay clean electronic claims in 30 days, or clean paper claims in 45 days, or deny payment for services within 30 days of receipt for a clean electronic claim or within 45 days of receipt for a clean paper claim. The implementation and adherence to this

standard will facilitate timelier resolution of most provider inquiries regarding claims payment status since they will receive either payment or denial notices within a shorter period of time than today.

6. OCC's intent is to create a national contact center that will handle medical claim inquiries from community providers not associated with CCN contracts. OCC has also continued to work closely with providers to ensure they have access to the Vendor Inquiry System which provides a "self-serve" option for resolving medical claim inquiries. VA expanded VIS capabilities in October 2017 to allow providers to view VA's Fee Basis Claim System inventory and claims processing data on demand.
7. VA has included specific requirements and more stringent standards in the CCN Request for Proposal (RFP) for provider payment processing and timeliness. Future contractors are required to process and adjudicate 98 percent of all clean claims within 30 days of receipt. Further, the contractor must always return claims, other than clean claims, to the provider with a clear explanation of deficiencies within 30 days of original receipt. VA believes that its contract incentives and processing standards will also promote payment to providers within 30 days of a clean claim submission, thus improving overall provider satisfaction, payment timeliness and decreasing the potential for Veterans to be billed for the services.
8. VA established oversight monitoring procedures and controls under the Veterans Choice Program (VCP), and will continue to do so under the CCN contract. Among the key oversight activities performed, VA conducts face-to-face quarterly performance management reviews with the Third Party Administrators (TPA) and as performance deficiencies are identified, VA issues a formal Letter of Correction, which the TPA must respond to with a written corrective action plan for VA approval. VA's implemented procedures also include controls to ensure that performance-related data is regularly reported by the TPAs in a timely and consistent manner and is analyzed monthly by both TPA and VA staff. These oversight processes have helped improve TPA performance over the life of the VCP contract and similar results are anticipated once CCN is implemented.
9. To ensure timely resolution of provider inquiries and enhanced customer service in the future under CCN contracts, VA also included in the CCN RFP performance requirements and standards related to a Provider Call Center and its operations. Requirements include, at a minimum, toll-free telephone lines, access to a Real Time Chat function, and automated phone call back.
10. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(Original signed by)

Richard A. Stone, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan**

OIG Draft Report, Veterans Health Administration: Allegation that Community Care Providers No Longer Accepted VA Authorizations, Fayetteville NC

Date of Draft Report: August 1, 2018

Recommendations/ Actions	Status	Target Completion Date
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Recommendation 1. The Executive in Charge, Office of the Under Secretary for Health, ensures community care provider participation is effectively monitored at the local level to mitigate the risk of unidentified gaps in specialty care coverage.

VA Comment: Concur.

The Department of Veterans Affairs (VA), along with the Community Care Network (CCN) Contractors, will measure and monitor network adequacy through an approach that includes regular and interactive meetings and a new provider profile Information Technology tool. This approach and other improvements VA is planning will ultimately ensure local and national VA staff has enhanced access and information on the entire nation-wide community care provider base and within each region.

VA has been developing a Provider Profile Management System (PPMS). The PPMS is a consolidated repository that will house nation-wide provider and facility information from CCN providers, providers under VA Provider Agreements, and eventually, will include other providers such as those working in Indian Health Service and Department of Defense facilities. PPMS will offer provider profile information and interface to multiple VA applications to support reporting and analysis capabilities. It will allow the ability to confirm provider availability in the CCN and will include search function capabilities to allow VA local and national staff to view the results of searches filtered by treating specialties and physical locations. PPMS will not be used to measure network adequacy, but rather, will provide an inventory of available providers to enable better network coverage and gap analysis and reporting at multiple levels across the VA health care system.

PPMS is scheduled to be rolled out to the field in September 2018. Data in PPMS will initially be limited to providers operating under VA Provider Agreements. Additional provider information will be added to PPMS over time. For example, CCN contractor information will be electronically populated in PPMS as part of CCN start-up and implementation activities. CCN Contractors will then maintain information on their providers, practitioners and facilities via regular and ongoing transmissions of updates. Future PPMS data releases and enhancements, beyond those identified here, have not yet been scheduled, but are being worked by the project management team.

VA is also anticipating that both monthly and quarterly meetings will be conducted to review network adequacy at multiple levels in the organization. VA will develop a quarterly communication plan between VA Central Office, the Veterans Integrated Service Network, and the VA medical centers (VAMC), to determine the risk of gaps in specialty care coverage, and to discuss implementation of mitigation strategies. As well, CCN Request for Proposal (RFP) requirements include provisions for the CCN Contractor to conduct monthly network adequacy meetings with VAMCs and VA stakeholders. These

meetings will discuss network performance, anticipated changes in network demand and review of network adequacy deliverables.

As a reminder, VA has specified in the RFP that the CCN Contractor must maintain a network of providers and practitioners that will extend across the entirety of each CCN Region and must be sufficient in numbers and types of providers, practitioners, and facilities. Network Adequacy will be determined for each VA facility located in the awarded CCN Region and by specific categories of care and will be measured by geographic accessibility (drive-times) and appointment availability (timeliness). Where CCN access in a region is deemed by VA to be inadequate, the contractor will be required to recruit additional providers and practitioners currently practicing in the area to participate in the CCN.

VA will provide the following documentation at completion of this action:

- Executed CCN Region 1 Contract annotating Network Adequacy and Monitoring
- Confirmation of initial PPMS deployment (September 2018)
- Quarterly communication plan for network adequacy meetings

Status:
In Progress

Target Completion Date:
December 2018

Recommendation 2. The Executive in Charge, Office of the Under Secretary for Health, ensures the Veterans Integrated Service Network 6 Claims Adjudication and Reimbursement office identify and dedicate the appropriate number of staff needed to timely process Non-VA Care medical claims.

VA Comment: Concur.

Since January 2018, the VA Office of Community Care (OCC) has been increasing claims processing staff support to ensure timelier processing of non-VA care medical claims. OCC's claims backlog peaked in June 2018, at 1.078 million but has been reduced by 215,000 claims since then. With the additional staff support, the percentage volume of backlogged authorized claims awaiting adjudication has been reduced from 30 percent down to 15 percent. Claims processed in the last 30 days are now at 1.7 million claims, an increase of nearly 600,000 claims processed per month over Quarter 1 fiscal year (FY) 2018. Further improvements will occur over time. VA is targeting June 2019, for meeting the MISSION Act-directed timeliness standard of processing a clean electronic claim within 30 days and clean paper claim processing within 45 days of receipt.

OCC has now also created a staffing and workload model for claims processing workload balancing. The model will enable better planning for upcoming impacts from changes associated with the MISSION Act, Community Care Network roll-out, the transition from the Patient-Centered Community Care and Veteran Choice Program, as well as potential volume impacts from adoption of the new adjudication system for non-network claims.

VA will provide the following documentation at completion of this action:

- VA processing trends and timeliness metrics
- Staff and workload projection model

Status:
In Progress

Target Completion Date:
June 2019

Recommendation 3. The Executive in Charge, Office of the Under Secretary for Health, ensures the Veterans Integrated Service Network 6 Claims Adjudication and Reimbursement office implements specific controls to ensure staff are not inaccurately rejecting Non-VA care claims, or rejecting claims for the wrong reasons.

VA Comment: Concur.

The VA Office of Community Care (OCC) is taking several steps towards ensuring that claims are being correctly adjudicated by staff. In August 2017, OCC standardized rejection and denial reason codes and developed and implemented job aides providing enhanced direction to field staff. Reasons not approved for use were deactivated in the system at that time and reports were developed to flag the use of non-standardized denial/rejection reasons. Starting August 2018, these reports will be analyzed monthly to ensure non-standard reasons are not added.

OCC has also begun to standardize and improve the claims processing quality assurance process. OCC is creating quality review criteria along with an Internal Review Standard Operating Procedure (SOP) that will be provided to the field. The use of specifically defined quality review criteria will ensure that adjudication data will be collected, trended and analyzed on a variety of errors, including the application of incorrect rejection/denial reasons. Review and discussion of this information with field supervisors and staff will focus on identifying and initiating further corrective actions to address negative and inappropriate trends. Such corrective actions may include retraining of staff and updating the SOP with clarifications, corrections and/or enhancements. Activities related to the quality assurance actions are currently in the planning stage with targeted completion set for January 2019.

VA will provide the following documentation at completion of this action:

- Rejection/Denial code job aide and monthly report used to identify non-standardized reason codes
- Internal Review Standard Operating Procedure

Status:
In Progress

Target Completion Date:
January 2019

Recommendation 4. The Executive in Charge, Office of the Under Secretary for Health, implements controls to ensure VA staff timely resolve medical claim inquiries from community providers.

VA Comment: Concur.

VA currently has several different channels community providers can use to submit medical claim inquiries. These different channels are available to ensure providers can access information via self-service portals as well as with a live customer service representative. For each of these channels, VA works to ensure that there is a process in place to track both the receipt of the inquiry and its resolution.

The MISSION Act requires VA either pay clean electronic claims in 30 days, or clean paper claims in 45 days, or deny payment for services within 30 days of receipt for a clean electronic claim or within 45 days of receipt for a clean paper claim. The implementation and adherence to this standard will facilitate timelier resolution of most provider inquiries regarding claims payment status since they will receive either payment or denial notices within a shorter period than today.

For the various avenues that VA has in place to receive or service community provider inquiries, VA has implemented metrics that are tracked to gauge use, handling time, and other aspects of customer service. This includes:

Expanded VA Call Center: In September 2017, the VA Office of Community Care (OCC) Contact Center began assisting with medical claim inquiries received from community providers for Veterans Integrated Service Network (VISN) 6. Since this time, VA has handled a total of 43,177 calls from community providers for this VISN. OCC's intent is to create a national contact center that will handle medical claims inquiries from all VISNs nation-wide. Currently, the Contact Center handles calls for VISNs 2, 6, 9, 11, 16 and 20 and Adverse Credit Reporting call lines nationwide. OCC's plan for a national contact center for providers includes the hiring of additional staff, analyzing internal processes and procedures, and implementing measures and standards to ensure efficiency and effectiveness of call handling. VA will continue to follow its current call center standards, which include a call abandonment rate of 7 percent or less.

VA's Vendor Inquiry System (VIS) for Self-Service: In addition to VA's call center plans, OCC has continued to work closely with providers to ensure they have access to VIS, which provides a "self-serve" option for resolving medical claim inquiries. VA expanded VIS capabilities in October 2017, to allow providers to view VA's Fee Basis Claim System inventory and claims processing data on demand. Through VIS capabilities, providers can obtain claim status, as well as extract appropriate claims data, and easily compile reports. Access requests during fiscal year FY2017 were 3,800 on average per month. Since VIS expansion in FY2018, average monthly requests for access are nearly 15,000 per month demonstrating a sharp increase in usage.

VA will provide the following documentation at completion of this action:

- OCC Provider Contact Center Implementation Strategy and Plan
- VIS – Fact Sheet and User Access Statistics

Status:
In Progress

Target Completion Date:
June 2019

Recommendation 5. The Executive in Charge, Office of the Under Secretary for Health, implements oversight procedures to ensure community care contractors effectively notify community providers when they reject their claims.

VA Comment: Concur.

While VA cannot currently enforce timely payment expectations under the current Veteran Choice Program (VCP)/Patient-Centered Community Care Program contract conditions, VA does now monitor third party administrators (TPA) timeliness statistics and addresses reported deficits with them monthly. Numerous processing improvements implemented over the past two years have had a significant impact on TPA payment performance. For the month of June 2018, TriWest processed 97.89 percent of clean claims within 30 days and 99.31 percent total within 45 days and had an average date to payment of 27 days. Health Net, on the other hand, processed 58.3 percent of clean claims within 30 days and 79.9 percent total within 45 days. The VA has chosen not to exercise the next contract option year for Health Net, so Health Net services will end September 30, 2018.

Looking to the future, VA has included specific requirements and more stringent standards in the Community Care Network (CCN) Request for Proposal (RFP) for provider payment processing and timeliness. Section 12.4a of the CCN RFP includes a provision that the Contractor must always process and adjudicate 98 percent of all clean claims within 30 days of receipt. Further, the contractor must always return claims, other than clean claims, to the provider with a clear explanation of deficiencies within 30 days of original receipt. The RFP also includes requirements related to contract incentive/disincentive factors (IDF) for provider education and claims payment and accuracy. The IDF will encourage the TPAs to place extra effort towards ensuring that the claims process is easy for providers to

understand and use. As well, it provides an incentive for educating providers to support their submission of accurate and “clean” claims.

VA believes that these types of incentives and processing standards will promote payment to providers within 30 days of a clean claim submission, thus improving overall provider satisfaction, payment timeliness and decreasing the potential for Veterans to be billed for the services. The 30 day payment and communication standard is also one incorporated into the recently signed MISSION Act and affects VA payment processes. The MISSION Act establishes a prompt payment process that requires VA to pay for, or deny payment for, services within 30 days of receipt of a clean electronic claim or within 45 days of receipt of a clean paper claim.

VA has established under VCP, and will continue to implement under CCN, contractor oversight monitoring procedures and controls. The Quality Assurance Surveillance Plan (QASP), pursuant to the requirements listed in the contract’s performance work statement, sets forth the procedures and guidelines VA uses to ensure the required performance standards and service levels are achieved by the TPAs. Among the key oversight activities performed, VA conducts face-to-face quarterly performance management reviews with the TPAs and as performance deficiencies are identified, VA issues a formal Letter of Correction, which the TPA must respond to with a written corrective action for VA approval. VA’s implemented procedures also include controls to ensure that performance-related data is regularly reported by the TPAs in a timely and consistent manner and is analyzed monthly by both TPA and VA staff. The QASP oversight processes have helped improve TPA performance over the life of the VCP contract and similar results are anticipated once CCN is implemented.

VA will provide the following documentation at completion of this action:

- Executed CCN Region 1 contract with language pertinent to the recommendation’s response.
Status: In Progress Target Completion Date: August 2019

Recommendation 6. The Executive in Charge, Office of the Under Secretary for Health, implements oversight procedures to ensure community care contractors effectively resolve medical claim inquiries from community providers.

VA Comment: Concur.

In January 2018, the VA launched the “Top 20 Provider Initiative” to work directly with community providers having high dollar amounts of unpaid claims and to enable more timely resolution of ongoing claims payment issues. Since current VA contract provisions, do not provide VA the ability to monitor and assess the timeliness by which the Third-Party Administrators (TPAs) resolve medical claim inquiries from their community providers, VA’s Top 20 initiative included creating rapid response teams to work with the TPAs and their community providers to settle unpaid claim balances within 90 days.

To ensure timely resolution of provider inquiries and enhanced customer service in the future under Community Care Network (CCN) contracts, Section 6.2 of the CCN Request for Proposal (RFP) includes performance requirements and standards related to a Provider Call Center. Requirements include, at a minimum, toll-free telephone lines, access to a Real Time Chat function, and automated phone call back, to respond to online and telephonic inquiries from CCN providers related to a variety of categories including: status of referrals, prior authorization status, claims status and issues, and complaints.

Section 6.8 of the CCN RFP further details the Call Center Operations and Customer Service Technology Performance Requirements and Metrics. The contractor must provide a monthly report on their call center

operations summarizing call center inquiries, performance metrics, open issues, and trends. Call center handling standards include the following:

Provider Inquiry Call Center Handling Standards

<u>Metric</u>	<u>Performance Rate</u>
Call Abandonment Rates	5 percent or less
Average Speed of Answer	30 Seconds or less
First Call Resolution	85 percent or higher
Response Accuracy	90 percent or higher
Real-Time Chat Satisfaction	90 percent or higher

Finally, Section 6.7 of the CCN RFP provides that the contractor will be required to submit a quarterly provider satisfaction survey report of all community providers who submitted claims that quarter. The Contractor must report to VA the results of such surveys 60 days following conclusion of the survey quarter. The data provided in the quarterly reports and in the quarterly face-to-face PMRs shall be used to review performance, identify emerging issues and address current issues, and maintain an effective customer service relationship between the contractor and VA.

VA has established under Veteran-Community Partnership, and will continue to implement under CCN, contractor oversight monitoring procedures and controls. The Quality Assurance Surveillance Plan (QASP), pursuant to the requirements listed in the contract's performance work statement, sets forth the procedures and guidelines VA uses to ensure the required performance standards and service levels are achieved by the TPAs. Among the key oversight activities performed, VA conducts face-to-face quarterly PMRs with the TPAs and as performance deficiencies are identified, VA issues a formal Letter of Correction, which the TPA must respond to with a written corrective action plan for VA approval. VA's implemented procedures also include controls to ensure that performance-related data is regularly reported by the TPAs in a timely and consistent manner and is analyzed monthly by both TPA and VA staff. The QASP oversight processes have helped improve TPA performance over the life of the VCP contract and similar results are anticipated once CCN is implemented.

VA will provide the following documentation at completion of this action:

- Executed CCN Region 1 contract with language pertinent to the recommendation's response.

Status:
In Progress

Target Completion Date:
August 2019

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended

OIG Contact and Staff Acknowledgments

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